TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-17-1644-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
JANUARY 31, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied no preauthorization obtained. The reconsiderations were sent in and denied after reconsideration. We are no requesting Medical Fee Dispute Resolution."

Amount in Dispute: $349.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bill was reviewed and it was determined that ESIS will stand on the original denial code of 'unrelated to the compensable injury.' Per the attached peer review and Decision & Order, the medications are unrelated to the compensable injury [injury]."

Response Submitted by: ESIS

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
March 16, 2016 and April 14, 2016	Prescribed Medication	$349.30	$61.95

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference
4. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
5. 28 Texas Administrative Code §134.503 sets out the sets out the Pharmacy Fee Guidelines for the workers' compensation.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W12 – Charge unrelated to the compensable injury
   - 197 – Precertification/authorization/notification absent
   - 662 and 5 – No proof of pre-auth

Issue(s)

1. Does the medical fee dispute referenced above contain information/documentation to support that date(s) of service April 14, 2016 contain an unresolved extent-of-injury issue?
2. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
3. Did the requestor submit documentation to support that the disputed medication rendered on March 16, 2016 did not require preauthorization?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication rendered on April 14, 2016. Review of the submitted documentation finds that the medical fee dispute contains an unresolved issues of extent-of-injury for date of service April 14, 2016. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process. The insurance carrier denied/reduced the disputed service(s) with denial reason code(s), "W12 – Charge unrelated to the compensable injury."

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury issue. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. The Division finds that the dispute contains an unresolved extent-of-injury issue for this dispute. As a result, the dispute is not eligible for review by MFDR until final adjudication of the extent-of-injury issue.

   The Division hereby notifies the requestor that the appropriate process to resolve the extent-of-injury issue for date of service April 14, 2016, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent-of-injury issue is attached.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute, for date of service April 14, 2016, may be submitted for review as a new dispute and is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute. The Division finds that disputed service April 14, 2016 is dismissed and not eligible for review until final resolution of the extent-of-injury issues.

2. The requestor seeks reimbursement for prescribed medication rendered on March 16, 2016. The insurance carrier's position statement asserts that "Upon receipt of the MDR request, the bill was reviewed and it was determined that ESIS will stand on the original denial code of 'unrelated to the compensable injury." Review of the EOBs presented by the insurance carrier and the requestor finds the following:

   Date of Service March 16, 2016

   EOB review date, April 11, 2016 contains the following denial reason code(s):
   - 662 – No proof of pre-auth

   EOB review date October 25, 2016 contains the following denial reason code(s):
   - 197 – Precertification/authorization/notification absent
   - 5 – No proof of pre-auth

   To determine whether such an extent-of-injury or related dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code § 133.240 (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service(s) was/were not related to the compensable injury: Per 31 TexReg 3544, 3558 (April 28, 2006), those provisions, in pertinent part specified: Former 133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee."

No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment. The Division concludes that the respondent has not met the requirements of 408.027. This new defense reason is therefore not supported for date of service March 16, 2016**.** This disputed service is therefore reviewed per applicable Division rules and fee guidelines.

3. Review of the Pharmacy page found at the TDI, Division of Workers' Compensation webpage explains when a prescribed medication requires preauthorization. The Division states the following, "As of September 1, 2013, the pharmacy closed formulary applies to all claims regardless of date of injury. Pharmacy closed formulary includes all FDA approved drugs. Preauthorization is required for drugs identified with a status of "N" in the current edition of the ODG , any compound that contains a drug identified with a status of "N", and any investigational or experimental drug as defined in Texas Labor Code §413.014(a)." Review of the Appendix A "N" Drugs in *Official Disability Guidelines - Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary*" for disputed date of service, March 16, 2016 identifies the disputed medication, Acetaminophen/codeine, as a "Y" status drug, therefore not requiring preauthorization. The requestor submitted a copy of the "Appendix A, ODG Workers' Compensation Drug Formulary which supports the Division's findings that the disputed medication is noted as a "Y" drug and therefore does not require preauthorization. As a result, the Division finds that the insurance carrier's denial is not supported and the requestor is entitled to reimbursement for the medication dispensed on March 16, 2016.

4. Per rule 134.503 "(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of: 1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed: (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount..." Using the above formula to determine the fee schedule, the Division arrived at a reimbursement of $61.95 for the prescribed medication dispensed on March 16, 2016.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement for the prescribed medication dispensed on March 16, 2016 in the amount of $61.95. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $61.95.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $61.95 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.